7: Furnivall G-4, 5 (no date) 1948 ALI Southeast Asia ALI

titioners and patients do not know the difference and buy the cheapest.[1]

These probably are among the chief reasons why 'the systems of oriental medicine have fallen into decay'. The task of improving the standard of health in the tropics is aggravated by the fact that western medical science usually reaches the people as one aspect of economic penetration, and must first be applied towards repairing and preventing the mischief naturally consequent on the process of development. A solution of the problem has been attempted along two lines: the provision of medical assistance; and the introduction of modern hygiene. It is important to notice the essential difference between these alternatives. Medical assistance aims to promote *individual* welfare, and ordinarily requires the voluntary co-operation of the patient; hygiene aims to promote *social* welfare, and necessarily involves a certain measure of compulsion.

2. MEDICINE

Ordinarily the introduction of western medicine in the tropics originates in the needs of Europeans. From very early days the East India Company arranged with the Apothecaries Company for the supply of barber-surgeons to their ships and settlements. In Africa likewise the various administrations at first confined the provision of medical services to the needs of their own establishments. But administrative establishments are partly native, and non-officials in commerce and industry require medical attention. In Burma the earliest members of the general public to receive the benefits of western medical skill were the convicts in jail, and the expansion of medical services in the interior has been closely bound up with the growth of crime. It is only natural that generally throughout the tropics the provision of medical assistance has developed with the economic demand for doctors, and has been organized so as to cost no more than necessary.

But the spread of western medicine in the tropics has not been due solely to the growing demand for doctors; it has been due in part to the demand for patients. Medical missionaries look for patients. It is true that missionary organizations need doctors to preserve the lives of missionaries. But they have also recognized in western medicine an instrument for extending their influence among the people. To deliver their message they must find some method of

[1] *RPI* (India), 1897–1902, p. 243; *CISM*, pp. 13, 15, 23.

7: Furnivall G-4, 5 (no date) 1948 ALl Southeast Asia ALl

attracting listeners. Where, as under direct rule, the people want education in order to get jobs, missionaries have provided schools. Where, as under indirect rule, education has had less market value, they have provided hospitals. Missionaries have sought patients in the cause of welfare, hoping that by saving life they might rescue souls. Moreover the demand for patients has not been wholly altruistic. On western enterprise employers have come to recognize the economic value of providing medical attention for their labourers, in the hope that by improving health they might save labour. In Java under the Culture system the Government produce depended on the well-being of the plantation coolies and, in the forties, when the pressure on the labour supply led to famine and depopulation, it could no longer be disregarded. Thus, so early as 1851, a start was made in the training of natives in western medicine. In the same year Protestant missionaries were admitted. In Burma, developed by native enterprise under direct rule, missionaries have specialized in education, but in Java, developed by western enterprise under indirect rule, medical work presented a more favourable opening.

It is true, of course, that medical missions have looked on the provision of medical care as a good thing in itself, apart from ulterior motives, and that administrations and employers have been actuated by human sentiment in providing and extending medical facilities. Ordinarily the chief factor in stimulating humanitarian impulse has been the shock occasioned by a sensational outbreak of disease. In Siam the modern medical service dates from an epidemic of cholera in the early eighties; the ravages of sleeping sickness in 1901–2 focussed British attention on Uganda; shortly afterwards the outbreak of plague advertized the need for medical care in India and the Tropical Far East. But humanitarian considerations have been reinforced by the practical requirements of western enterprise, and it is in regions developed by western enterprise that medical work has made most progress. Of the hospitals in Java, other than dispensaries, about two-thirds are private institutions, and in the Outer Provinces nine-tenths.[1] In Malaya, before the late war, the tin and rubber companies were maintaining 232 hospitals. In Ceylon about three times as many were provided by companies managing estates, and there were about an equal number of Government dispensaries together with 93 State hospitals.[2] But Asiatic owners and

[1] *Netherlands India*, p. 380.
[2] *Britain and Her Dependencies*, pp. 29, 30.

7: Furnivall G-4, 5 (no date) 1948 ALI Southeast Asia ALI

managers often have little faith in western medicine and are reluctant to incur expenditure that they think of doubtful value, and Europeans, to protect their own interests, demand legislation to bring such estates up to their own levels.[1] On the other hand, some regions, where western enterprise is backward or unprofitable, are very scantily supplied with hospitals.

In these circumstances, though policy may be inspired by humanitarian zeal for human welfare, the spread of western medicine is dominated in practice by economic factors. The Government must provide first for its European staff and for natives in its own service, civil or military, for convicts in jail and for the requirements of criminal administration, and for Europeans engaged in economic development. Efficiency and the numerous other demands on public revenue require that such services should be rendered at as little cost as possible. Often, as in Burma and in parts of Africa, the easiest and cheapest way is to import foreign medical subordinates and menials.[2] These conditions tend to stress the importance of hospital discipline rather than to encourage human sympathy; as Lord Hailey remarks, 'It must need a great deal of skill and personal sympathy on the part of the European staff to overcome the impression left on the African by the discipline and isolation from friends which is the rule in many of the British hospitals.' We have noticed that in Burma the people regard the hospitals 'with fear and mistrust'. In Malaya the cult of efficiency and economy has led to the building of large central hospitals to which patients can easily be brought by ambulance, but where they are cut off from their friends. Similarly in Africa much money has been spent on imposing buildings that alarm rather than attract the people.[3] Even in England hospital discipline is often irksome, but the patient accepts it as necessary; to tropical peoples the need for discipline is less apparent, and it is exercised more rigorously. A tradition of human sympathy is characteristic of the healing art in Europe and also in great measure among native medical practitioners,[4] and a good bedside manner is a valuable asset to the private practitioner, whether of modern western or traditional native medicine. But kindliness is less important to native medical subordinates who regard medicine as one branch, and not the most highly esteemed or best-paid branch, of Government service, and it is easier to teach them

[1] Mills, p. 309.
[2] *Ib.* pp. 1195–6; Mills, p. 308; *CBC*, p. 33.
[3] *African Survey*, p. 1183.
[4] Landon, p. 115.

?: Furnivall G-4, 5 (no date) 1948 AL1 Southeast Asia AL1

things required for their examinations than to inspire them with professional traditions.

Medical science, then, serves to further economic progress rather than to promote native welfare. Economy forbids that Government shall spend more on medical assistance than will meet the demand at the least expense, and the demand is limited even more closely by economic factors. Employers who recognize that sickness involves a costly waste of labour can provide medical assistance,[1] and can insist as a condition of employment that their employees shall accept it. Personal interest in the well-being of their staff often induces them to press this doctrine to its farthest limits, but they must submit to the test of annual accounts to shareholders, and they cannot sacrifice efficiency to welfare without risking the loss of business to their competitors. Although missionaries can take more altruistic views, they find most scope for their activities in providing Government and western enterprise with medical facilities for their employees, and Christianity is enlisted in the cause of commerce.

It is not the case, therefore, that economic development is necessary as a condition of providing funds for medical services to the people, but medical services are necessary as a condition of economic development. The progress of medical science *as an instrument of welfare* depends on the organization of a demand for it among the people. How far tropical peoples voluntarily avail themselves of western medical assistance is uncertain; in Burma, as in Africa, they are readier to believe in western surgery which shows results than in western medicine of which the results are slower and less obvious. In general, western medical science has found little favour.[2] Burmans, we are told, 'don't care for English medicine'. In Siam western medicine has been encouraged since 1880, by their own King and not by foreign rulers, but 'in 1939 the old style doctor was still the one to whom the people ordinarily turn in times of sickness'. In Java, where natives have been trained to practise western medicine for nearly a hundred years, the people still have greater confidence in their own system, and in the general hospitals 40 % of the beds are empty because the people do not realize the benefits of western medicine.

[1] *African Survey*, p. 1194.

[2] *CISM*, pp. 1, 22; Leeuw, H. de, *Cross Roads of the Java Sea* (1931), p. 109. Fischer, Dr I. A., *Bulletin* Colonial Institute, Amsterdam, 1939, p. 24; Landon, p. 114; *Rural Hygiene in Indo-China* (1937), pp. 11, 50.